Checklist of Items
To be included in Grievance and Appeals Section
Of a Health Insurance COC or Policy (Health Benefit Plan)

Internal and External Appeal

( ) 1. An insurer shall not provide or perform utilization reviews without being registered with the Department — KRS 304.17A-607(1).

( ) 2. Disclosure of availability of an internal appeal process — KRS 304.17A-617(1) and of an external review of an adverse determination or coverage denial with a medical issue by an independent review entity certified by the Office — KRS 304.17A-623(1).

( ) 3. Notification that an internal appeal may be requested if a service, treatment, drug or device is specifically limited, excluded, or denied by the insurer (coverage denial or adverse determination) or if an insurer fails to make a utilization review determination and provide written notice within the time frames set forth in KRS 304.17A-607 & KRS 304.17A-617.

( ) 4. Standard internal appeal decision must be provided within thirty (30) calendar days; or three (3) business days for an expedited review decision — KRS 304.17A-617(2)(a)(b).

( ) 5. Provision that an external review of an adverse determination may be afforded by the insurer if:
   (a) The insurer, its designee, or agent has rendered an adverse determination;
   (b) The covered person has completed the insurer's internal appeal process; the insurer has failed to make an internal appeal decision as required by KRS 304.17A-617(2); or the insurer and covered person jointly agree to waive the internal appeal process;
   (c) The covered person was eligible on the date of service or at the time the covered service will be rendered; and
   (d) The entire course of treatment or service will cost at least $100, if the covered person had no insurance — KRS 304.17A-623(3).

( ) 6. Definition of "adverse determination" — KRS 304.17A-600(1).

( ) 7. Definition of "coverage denial" — KRS 304.17A-617(1).

( ) 8. Disclosure that an internal or external appeal may be requested by a covered person, an authorized person, or provider acting on behalf of the covered person within 60 days of a denial letter (timeframe may be longer but no less than 60 days) or if the insurer fails to render a utilization review decision and provide notification within the timeframes as required by KRS 304.17A-607(2), 806-KAR 17:280, Section 7 & KRS 304.17A-623(2)-(4) Relating to new clinical information KRS 304.17A-619(1).

( ) 9. Provision for an expedited internal or external appeal if the covered person is hospitalized or, in the opinion of the treating provider, a review under a standard time frame could, in the absence of immediate medical attention, result in any of the following:

(a) Placing the health of the covered person or, with respect to a pregnant woman, the health of the covered person or her unborn child in serious jeopardy;
(b) Serious impairment to bodily functions; or
(c) Serious dysfunction of a bodily organ or part — KRS 304.17A-617(2) & KRS 304.17A-623(10).

( ) 10. Instructions for requesting an oral (expedited) or written (non-expedited) appeal, including the position and telephone number of a contact person who can provide information relating to an internal or external appeal — 806 KAR 17:280, Section 4 & 806 KAR 17:290, Section 2.

( ) 11. Availability of a review by the Office (coverage denial), or an independent review entity certified by the Office (adverse determination or coverage denial with medical issue), if:
(a) the covered person, authorized person or provider is dissatisfied with the internal appeal decision;
(b) an internal appeal decision is not rendered within the required timeframes (coverage denial or adverse determination); or
(c) the insurer and covered person agree to waive the internal appeal process (adverse determination). (Instructions for requesting an external review should be given, including the address of the Office for external review of a coverage denial) — KRS 304.17A-617(3) & KRS 304.17A-623(8)(a).

( ) 12. Notification that the insurer will be responsible for the cost of the external review; however, the covered person will be assessed a filing fee of $25, which may be waived in case of financial hardship or refunded if the external review decision favors the covered person — KRS 304.17A-625(5) & KRS 304.17A-623(5).

( ) 13. Provision that consent will be obtained which authorizes the independent review entity to obtain all necessary medical records from both the insurer and any provider utilized for review purposes regarding the decision to deny, limit, reduce or terminate coverage, as well as the position and telephone number of a contact person for external review — KRS 304.17A-623(4).

( ) 14. Statement relating to the confidentiality of medical records and the external review process — KRS 304.17A-623(9).